# Guidelines for Completion of Medical Exemption Forms

It has been the intent of the Kentucky General Assembly that **all** students participate in the assessment and accountability components of KRS 158.645-KRS 158.6455.

The few exceptions currently allowed include those few students who cannot complete either the regular or alternate assessment components even with allowable accommodations or modifications due to medical or mental health conditions.

*It's important to note that a student's handicapping condition cannot be used as the justification for a medical exemption. Because these children must be educated with the handicapping condition, they must also be assessed with the condition using accommodations, modifications or both as appropriate.

If an accountable school feels that participation in the state-required assessment would be detrimental to a student's physical, mental or emotional well being, the school must complete the Medical Exemption form and obtain signatures from a physician and the student's parent/guardian; then return the form to the address at the bottom of this page. KDE staff will review the requests for Medical Exemptions. **The review considers the completeness (for example, signatures, date) of the form and the detail provided as to why the child's condition prohibits his/her participation in the state assessment program. However, completion of the form does not guarantee approval.**

The following bullets provide several examples of the type of medical conditions that are readily processed/approved:

- A student is seriously injured in an accident just prior to or very early in the testing window.
- A student is confined to home or hospital with an acute situation, not a long-term home/hospital instruction situation.
- A student is unable to interact with people without serious risk of infection or contamination to others.
- A student is pregnant with complications that endanger health of mother or child or has delivered just prior to or early in testing window.
- A student has a documented mental health crisis that makes him/her dangerous to self and/or others.

Return Medical Exemption Forms To:

Office of Assessment and Accountability
Attn: Kathy Moore
500 Mero Street, 18th Floor CPT
Frankfort, KY 40601
Secure Fax: (502) 564-3249

____*Approved* _____*Denied* _____*Date*

# Medical Exemption Form

**2005-2006 Commonwealth Accountability Testing System**

**Section 1 – *School/District use only. PLEASE PRINT OR TYPE.***

**A.** Exemption for: (*Please check the grade appropriate category or categories.)*

_____CTBS _____Kentucky Core Content Test _____Writing Portfolio _____A/NRT

**B.** Student information

Student's Last Name First MI

Student's Grade Level

District and School Student Attends

Attending District/School Number

Accountable District and School for Student (if different from above)

Accountable District/School Number

SSID
**(REQUIRED for grades 4, 5, 7, 8, 10, 11 and 12)**

Date of Diagnosis/Dates of Hospital Stay

District Assessment Coordinator Signature (**REQUIRED)**

Date of Request

Has the student been or is the student currently on homebound instruction?
**Yes No**

**Section 2 –*Physician use only. PLEASE PRINT OR TYPE.*** (*Attach additional pages if necessary.)*

Describe, in detail, this student's medical or mental condition and explain how participation in the state-required assessment would adversely affect his/her physical or mental condition. *(Please avoid the use of abbreviations.)*

**I understand my signature indicates that I believe participation in the state-required assessment would be detrimental to this student's well being.**

**Print or Type** Doctor's Name Doctor's Signature Date

Section 3 – I give permission to release my child's pertinent medical information to the school district representative, Kentucky Department of Education and the testing contractor (CTB/McGraw Hill) for the purpose of applying for a medical exemption from the 2005 state-required assessment. I understand that, pursuant to Public Law 104-191, all parties will keep this information confidential.

Parent or Guardian Signature Date

*Note: Completion of this form does not guarantee approval.*

____*Approved* _____*Denied* _____*Date*

# Model Authorization Form under HIPAA*

**This form should be used when release of a patient's protected health information is being made to anyone for a purpose other than treatment, payment or health care operations. The form should be adapted to meet the needs of a particular situation and a particular physician practice. Releases in which the form will be needed are discussed in the KMA HIPAA material regarding Authorizations. The information in brackets that is underlined should be filled in by the practice. Other information in brackets is designed to assist the patient in filling out the form.**

I, _____, hereby authorize _____ to use and/or disclose my
Name of Patient Name of Physician/Practice
protected health information described below to _____.
Name of Person or Entity to receive the information
My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]: _____
_____
_____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- ❑ Any and all records in the possession of _____ including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released]
  Name of Physician/Practice
- ❑ Records regarding treatment for the following condition or injury _____ on or about _____.
- ❑ Records covering the period of time _____ to _____.
- ❑ Other [please specify - include dates]_____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to _____.
Name and Address of Contact Person at the Practice
I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that _____ may not
Name of Physician/Practice
condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____.

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

*The source of this document is the Kentucky Medical Association.

*Note: Completion of this form does not guarantee approval.*